Missouri Pharmacy Program – Preferred Drug List

Long-Acting Narcotics

Effective 02/16/2005
Revised 04/02/2015

Preferred Agents

(Existing clinical edits may apply)

- Kadian®
- Duragesic®
- Morphine Sulfate ER Tabs
- Oxycontin®
- Butrans® Transdermal

Non-Preferred Agents

(Existing clinical edits may apply)

- MS Contin®
- Fentanyl Patches
- Avinza®
- Opana ER
- Oxycodone ER
- Oramorph SR®
- Embeda®
- Exalgo ER®
- Morphine ER Caps (gen Kadian)
- Oxymorphone ER
- **Zohydro® ER**
- **Hydromorphone ER**

Approval Criteria	Denial Criteria
Therapy for pediatric patients under 19 years of age subject to Clinical Consultant review.	Lack of appropriate diagnoses.
Documented appropriate diagnosis – see approval diagnosis box	Dosing outside or inferred opioid tolerance requirements
Failure to achieve desired therapeutic outcomes with trial on 3 or more preferred agents • Documented trial period for preferred agents • Documented ADE/ADR to preferred agents	Doses exceeding dose optimization limitations
Documented compliance on current therapy regimen	Lack of adequate trial on required preferred agents
	Therapy will be denied if no approval criteria are met
	Drug Prior Authorization Hotline: (800) 392-8030

Approval Diagnoses				
Condition	**Submitted ICD-9 Diagnoses**	**Inferred Drugs**	**Date Range**	**Client Approval (Initials)**
Cancer	140 – 208	NA	2 years	
Opioid Tolerance*	NA	Antineoplastics	12 months	
Chronic nonmalignant pain (CNMP):	282-355 710-733.7	NA	1 year	
	NA	Non-opioid analgesics	90 days	

*Inferred diagnosis of opioid tolerance required only for Oxycontin 80mg and 160mg tablets and Duragesic doses greater than 25mcg/hr.